Student Health Insurance

Policy Conditions
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ADVISOR
INTERNATIONAL HEALTH INSURANCE

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Art. A : Basis of the contract

A.1 : All statements in the insurance application and in any other written document, including medical reports, by the Insured or any person acting on his behalf are part of the insurance contract.

A.2 : The rights and obligations of the contracting parties are stated in the policy, in the endorsements and in the Policy Conditions (PC).

A.3 : In the event of a dispute as to the interpretation of this document, the French version shall be deemed authentic and shall take precedence over any version of the document in another language. The insured person can obtain a copy at any time on the website www.advisor-swiss.com

A.4 : The text written in the masculine gender shall also apply by analogy to persons of the female gender.

Art. B : Persons covered by the insurance

B.1 : The purpose of the contract is to provide foreign students who are staying in Switzerland for training or further training, as well as doctoral candidates and trainees, with reimbursement of medical, pharmaceutical and hospital expenses.

B.2 : The insured person can only benefit from this coverage if she simultaneously meets the following criteria :

- she is a foreign citizens
- she has her domicile in Switzerland
- she has a residence permit as a student or trainee
- she is not married to a person with a B activity residence permit, a C residence permit or a Swiss national
- she is exempt from the obligation to provide health insurance in accordance with art. 2.4 of the Health Insurance ordinance (OAMal)

B.3 : The insured person is fully responsible for verifying all eligibility criteria for exemption from the obligation to provide health insurance in accordance with art. 2.4 OAMal.

B.4 : The insured person must inform The Insurer of any change in the above criteria in writing within 30 days.

B.5 : The Swiss Health Insurance ordinance OAMal regulates the maximum period during which the insured person may be exempted from the obligation to take out insurance in accordance with art. 3 LAMal.

B.6 : The maximum age limit is 60 years old.

B.7 : The contract only covers the insured person indicated on the insurance certificate.

Art. C : Scope of the insurance

C.1 : In accordance with Care Plan chosen, medical, pharmaceutical and hospital expenses as shown on the insurance certificate.

C.2 : Based on art. 2.4 of the Health Insurance ordinance of 27th June 1995 (OAMal), this insurance program refers to the benefits provided by the Federal Law on Health Insurance (LAMal) of 18 March 1994 to guarantee the persons mentioned in art. B, an insurance cover equivalent to that provided by the LAMal. It is not complementary to the latter, but replaces this social insurance.

C.3 : Subrogation
Any person benefiting from the guarantee of the Insurer commits to subrogate Advisor International Health Insurance in his rights and actions against any responsible third party up to the amount of expenses engaged in the execution of this guarantee.

C.4 : Legal action
All legal actions arising under this insurance policy shall have a time limit of two years from the date of the event that gave rise to the action. Beyond this time The Insurer are not obliged to settle the claim.

C.5 : Currency
The applicable currency is the Swiss franc.

Art. D : Geographical scope of cover

The insurance is valid worldwide.

D.1 : Outside of Switzerland
During a stay of a maximum of 6 weeks, the insurance is valid only for expenses resulting from an accident or illness of an emergency nature as these terms are defined in art. I of the Policy Conditions (PC), provided that the treatment was performed by a doctor, general practitioner or specialist, or that the hospitalization was required by the direct cause of the emergency and that it occurs within 24 hours. In other cases, with the express agreement of The Insurer

D.1.1 : An emergency is herein defined as being a situation where the Insured, who is temporarily abroad or overseas, requires medical treatment and a return to Switzerland is not possible. There is no emergency when the person insured goes abroad or overseas for the purposes of treatment.

D.1.2 : The insured person will not be covered for non-emergency follow-up or therapeutic care.

D.1.3 : Charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth are excluded, unless The Insurer has given its written consent. In this case, the maximum amount for these benefits is CHF 5’000.

Art. E : Admission requirements

E.1 : Information and medical examinations
By signing the insurance application, the insured person authorizes doctors, health care providers, previous insurers and other insurance institutions to provide information to The Insurer or its medical advisors.

E.1.1 : The Insurer is entitled to order a medical examination at its own expense. The doctor may be appointed by The Insurer

E.1.2 : The insured person must undergo these medical appraisals to determine the diagnosis and clarify his entitlement to the benefits.

E.2 : Other parties
No other person, except an appointed representative, is authorised to make or confirm any change on behalf of the insured person, or decide not to enforce any of The Insurer. To be valid, any modification must be confirmed in writing by The Insurer.

Art. F : Acceptance, refusal, modification, start and end of the contract

F.1 : Agreement of the policy contract
If the content of the insurance certificate or amendments does not match the insurance application, the policyholder must then request the correction within 30 days of receipt of the certificate or amendments, failing which their content shall be considered accepted by the policyholder.

F.2 : Refusal
The Insurer may refuse an insurance application without justification.

F.3 : Modification of the contract by the insurance holder
For any amendment to the contract, a new insurance application must be completed. A new risk assessment is carried out.

F.4 : Inception of contract
The insurance cover commences on the day mentioned on the insurance certificate.

F.5 : Expiration of contract
The contract is bound for an undetermined period. It will be tacitly renewed year after year unless it is terminated by one of the parties in accordance with the terms outlined in art. F9 of the Policy Conditions (PC).

F.5.1 : When the insurance policy expires, the insured person is no longer entitled to reimbursement of medical expenses. Any eligible expenses incurred during the period of cover shall be reimbursed. However, any on-going or further treatment that is required after the expiry date of the insurance policy will no longer be covered.

F.6 : Termination of contract
F.6.1 : Termination by Insurer
F.6.1.1 : The Insurer expressly renounces its legal right to abandon the contract in case of claim, except in the case of false statements, abuse, conniving acts, withholding of information, insurance scam, or attempt at such, by the insurance holder or the Insured.

F.6.1.2 : The Insurer shall terminate the contract in any event for each insured person :

F.6.1.2.1 : If the insured person does not make every effort to inform and cooperate with The Insurer.

F.6.1.2.2 : If the insured person does not comply with the doctors' instructions.

F.6.1.2.3 : If the insured person does not do everything in his power to contain the damage to his health as far as possible.

F.6.1.2.4 : If the insured person takes part in risky actions and knowingly exposes himself to danger.

F.6.1.3 : The Insurer will terminate the contract in any event for each insured person :

- as soon as she loses his status as a student, doctoral student, schoolchild or trainee staying in Switzerland as part of a training or further training course
- as soon as she is no longer in possession of a valid and appropriate residence permit
- on his 60th birthday

F.6.1.4 : Insofar as The Insurer has already granted benefits for events occurring after the date on which the insured person ceased to be a student, doctoral student, schoolboy or trainee residing in Switzerland as part of a training or further training course, The Insurer is entitled to reimbursement of benefits already paid.

F.6.2 : Termination by the Insured
The contract may be terminated by the Insured for the purpose of an insurance year, observing a notice period of 3 months.

F.6.2.1 : In the event of a change of insurer, the policyholder shall communicate to The Insurer the confirmation of admission of the new insurer.

F.6.2.2 : In the event of departure abroad, the policyholder shall send The Insurer the certificate of departure.

F.7 : The insured person's insurance coverage will automatically terminate if it no longer meets the eligibility criteria set out in art. B of the Policy Conditions (PC).

F.7.1 : Insurance cover ends on the day the cancellation takes effect. The insured benefits are payable up to and including that day.

F.8 : Withholding of information, omission or misrepresentation
F.8.1 : Such pre-existing conditions are subject to full disclosure and medical underwriting. If such pre-existing conditions are not disclosed, The Insurer may terminate the insurance contract within four weeks of becoming aware of the withholding, omission or misrepresentation.

F.8.2 : The withholding, omission or misrepresentation changes the purpose of the risk or reduces its opinion for The Insurer, even though the risk omitted or misrepresented by the insured person or the policyholder has had no influence on the claim.

F.8.3 : If the person who was required to declare has, at the time of conclusion of the contract communicated, failed to declare or incorrectly declared a fact that he knew or should have known and about which he was questioned in writing, in particular in the following cases :

- of diseases
- existing accidents or disabilities
- diseases that, in experience, are prone to relapse
- of pregnancy and maternity

The Insurer applies the following clauses :

F.8.3.1 : The insurance contract is void in cases of concealment, omission or misrepresentation on the part of the Insured person or the policyholder.

F.8.3.2 : The premiums paid then remain vested in The Insurer, which is entitled to payment of all premiums due as damages.

F.9 : Any termination must be notified by registered mail.

Art. G : Payment of premiums

G.1 : Premium payments
Premiums are payable in advance. They are due on the first day of insurance coverage.

If the contract is terminated before its expiry date, premiums are reimbursed for the period before the expiry date. This rule does not apply in case of insurance abuse, and particularly in the case of insurance scam.

G.2 : Reminder and consequences of non payment
If the full premium or cost sharing is not paid in time, the debtor receives a written reminder, at his own expense, to make the payment within 14 days from the date of sending the reminder.

G.2.1 : If the full premium or cost sharing is not paid within the grace period thus granted, the debtor must be summoned in writing, at his own expense, to make payment within 14 days from the date of sending the summons. The summation must remind the consequences of the delay.

G.2.2 : If the summons remains without effect, the obligation of The Insurer shall be suspended as from the expiry of the 14 day period until all outstanding premiums have been paid.

The insurer must immediately inform the cantonal health insurance supervisory authority.

G.2.3 : If The Insurer do not take legal action to recover the premium, the insurance policy shall be deemed automatically cancelled two months after the expiry of the 14 day notice and no further termination letter will be issued to the insured person.

The insurer must immediately inform the cantonal health insurance supervisory authority.

G.2.4 : In the event of reminders, summonses and legal proceedings, the following costs are charged :

- reminder CHF 20
- summation CHF 20
- initiating debt enforcement CHF 50 (plus official enforcement costs and court costs)
- deletion of a debt enforcement CHF 80 (deletion will only be performed if all outstanding amounts have been settled)

G.2.5 : Claims against The Insurer cannot be offset against the premium. The insured person has no right of set-off against the Insurer.

G.3 : Change of payment method
The change in payment method can only be made on the renewal date of the insurance policy. The request must be received by The Insurer no later than 30 days before this date.

Art. H : Tariff adjustment

H.1 : Tariff adjustment
The Insurer may modify the premium rate and/or cost sharing (deductible and co-payment) in accordance with changes in medical care costs, claims costs, changes in the circle of service providers and their benefits, forms of therapy, changes in the scope of cover as well as legal changes.

In this case, The Insurer shall notify the policyholder of the new premiums or new provisions of the contract no later than 25 days before they enter into force.

Upon receipt of the new conditions, the insured person then has the right to terminate the contract for the date on which the new provisions come into force.

To be valid, the termination notified in accordance with art. F.9 of the Policy Conditions (PC), must reach The Insurer no later than the business day preceding the entry into force of the new contract. In the absence of termination, the insured person is deemed to accept the adaptation of the contract.

H.2 : Change of age group
When changing to the 30 to 60 age group, the deductible and insurance premium are adjusted when the insurance contract is renewed.

The insured person then has the right to terminate the contract within 30 days of receiving his new insurance certificate for the date on which the new provisions come into force.

To be valid, the termination must be notified in accordance with art. F.9 of the Policy Conditions (PC).

H.3 : Change of canton
The insured person who must change residence to one of the cantons listed below must inform The Insurer 30 days before making the change, but at the latest before changing canton.

If special conditions are required by the new canton of residence, The Insurer will inform the insured person and a new contract will be submitted. The insured person then has the right to terminate the contract for the date on which the new provisions come into force.

In order to be valid, the termination notified in accordance with Art. F.9 of of the Policy Conditions (PC), must be received by The Insurer no later than the working day before the new contract comes into force. If no notice of termination is given, the policyholder is deemed to have accepted the adjustment of the contract.

H.4 : Change of deductible
The transition to a new deductible can only be made on January 1st of each year. An insured person who wishes to change his deductible must request it by completing a new insurance application and sending it to The Insurer no later than 30 days before the effective date.

Art. I : Definitions

I.1 : Sickness
By sickness we understand a problem of physical or mental health not due to an accident but which requires an examination or medical treatment.

I.2 : Accident
By accident we understand any sudden, unintended damaging effect on the human body caused by an exterior factor beyond the control of the Insured.

I.3 : Maternity
Routine maternity refers to medically necessary costs incurred during pregnancy and childbirth.

I.4 : Medical practitioner
I.4.1 : General practitioner
Is a general physician who is licensed to practice medicine under the law of the country in which treatment is given and where he/she is practising within the limits of his/her licence.

I.4.2 : Specialist doctors
Is a qualified and licensed medical physician possessing the necessary additional qualifications and expertise to practice as a recognised specialist of diagnostic techniques, treatment and prevention in a particular field of medicine.

I.5 : Hospitals and clinics
Hospitals and clinics that are run and supervised by a doctor and that only receive sick or injured people.

Hospitals, nursing homes, homes for the elderly, medico-social institutions, homes for the chronically ill and other institutions not intended for the treatment of persons suffering from acute illnesses are not considered to be hospitals.

I.6 : Care facilities
By care facilities we understand recognised hydrotherapy treatment facilities, as per art. 40 of LAMal, as well as convalescence homes managed or supervised by an authorised medical practitioner.

I.7 : Deductible
This represents the amount indicated in the insurance contract which the insured person agrees to bear for each calendar year before being reimbursed by The Insurer.

I.8 : Co-payment
The additional cost borne by the insured person.

I.9 : Pregnancy
Refers to the period of time, from the date of the first diagnosis, until delivery.

I.10 : Medical necessity
Refers to those medical services or supplies that are determined to be medically necessary and appropriate. They must be :

- essential to identify or treat a patient's condition, illness or injury
- consistent with the patient's symptoms, diagnosis or treatment of the underlying condition
- in accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time. This does not apply to complementary treatment methods if they form part of the choses insurance cover
- required for reasons other than the comfort or convenience of the patient or his/her physician
- proven and demonstrated to have medical value
- considered to be the most appropriate type and level of service or supply
- provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition. This does not apply to complementary treatment methods if they form part of the chosen insurance cover
- provided only for an appropriate duration of time

As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to in-patient treatment, "medically necessary" also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided on an outpatient basis.

I.11 : Obesity
Is diagnosed when a person has a Body Mass Index (BMI) of over 30.

I.12 : Pre-existing conditions
Are medical condition or any related issue for which one or more symptoms have been displayed at some point during the lifetime of insured person, whether or not medical treatment or advice has been sought. Any health problem or related problem of which the insured person or his/her dependants could reasonably have known the existence, will be considered a pre-existing condition.

I.13 : Home country
Country of origin or country of citizenship of the insured person.

I.14 : Emergency
Constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

I.15 : Rehabilitation
Is treatment in the form of a combination of therapies such as physical, occupational and speech therapy and is aimed at the restoration of a normal form and/or function after an acute illness or injury.

The rehabilitation benefit is payable only for treatment that starts within 14 days of discharge after the acute medical/or surgical treatment ceases and where it takes place in a licensed rehabilitation facility.

I.16 : Assistance
Aid given to the insured person on the occasion of travel when an accident or some other insured incident occurs. A range of human, technical and, secondarily, financial resources are then deployed to assist the insured person.

I.17 : Relatives
Members of the same family (spouse, father and mother, children, parents-in-law, grandparents, brothers and sisters).

Art. J : Cost sharing

The insured person shares in the costs of the benefits granted to him. Cost sharing includes :

J.1 : Deductible
The deductible is indicated on the insurance certificate, it applies to all benefits and represents the amount that the insured person agrees to pay for each calendar year before being reimbursed by The Insurer.

J.2 : Co-payment
It amounts to 10% of the costs generated for the following cases :

- illness or accidents resulting from voluntary acts by the insured person such as self-inflicted mutilations or suicide attempts
- treatment related to drug addiction or alcoholism
- ethylic, severe alcoholism or if it is proven that Insured, at the moment of the accident, had a blood alcohol concentration (BAC) equal or superior to 0.50g/l
- psychotherapy
- alternative medicines

Art. K : Insurance guarantees

The following section gives a summary of the range of benefits which The Insurer offer. Please note that those available to the insured person will be listed in his Care Plan.

The claim benefits must be efficient, appropriate and economical. If any of these three conditions are not met, The Insurer reserves the right to refuse the claim for reimbursement.

K.1 : Benefit Limits
There are two kinds of benefit limits shown in the Care Plan. The overall limit of the Care Plan, applicable to certain coverages, is the maximum The Insurer will pay for all benefits in total, per insured person, per insurance period basis, per calendar year basis, under that particular Care Plan.

Some benefits also have a specific benefit limit. Specific benefit limits may be provided either by Insurance period basis, calendar year basis, lifetime basis or event basis. In some instances The Insurer will pay a percentage of the costs for the specific benefit.

K.2 : Medical practitioner fees
Fees of general practitioners and specialist doctors.

K.3 : Hospitalization
Admission to a psychiatric hospital or a clinic must be immediately communicated to The Insurer and no later than 6 days after admission. If a guarantee of cover is required, notification must take place before being admitted.

In case of hospitalization in Switzerland, only the costs in a public ward are covered related to :

- medical hospitalization in a state-run or private hospital
- hospitalization and surgical operation
- auxiliary medical and paramedical expenses incurred during hospitalization

K.4 : Prescribed drugs
Refers to Products prescribed by a physician and listed on the Specialty List (SPL) with the exception of commonly used non-drug products and off-list drugs (LL).

The prescribed drugs must be clinically proven to be effective for the condition, recognized by the pharmaceutical regulator in a given country and covered under the LAMal.

K.5 : Home care
Following a hospitalization period or to replace hospitalization, a maximum amount of CHF 20 per day is allocated, with a maximum of CHF 2’000 per calendar year.

K.6 : Psychotherapy
Sessions are only reimbursed if they are provided by a doctor using methods whose effectiveness has been scientifically proven and after presenting The Insurer with a diagnosis justifying them, made by a psychiatrist.

K.6.1 : Psychiatry and psychotherapy are covered when medically necessary and provided by a psychiatrist (or psychologist if treatment is prescribed and supervised by a psychiatrist) up to 15 diagnostic and therapeutic sessions.

K.6.2 : Additional sessions, up to a maximum of 15 sessions, may be covered if medically necessary, provided The Insurer receives in advance, a medical report containing the diagnosis, the treatment carried out, the results obtained so far, the purpose and the duration of the proposed extension.

K.6.3 : The Insurer will only reimburse the costs of psychotherapy delegated by a doctor to an approved psychotherapist for the purpose of clarifying and treating psychic or psychosomatic disorders.

K.6.4 : In all cases, the disorder must be associated with present distress or substantial impairment of the individual’s ability to function in a major life activity (e.g. employment). The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).

K.7 : Organ transplant
Full reimbursement. Organ procurement costs are not covered.

K.8 : Physical therapy
A maximum amount of CHF 500 per day is allocated for a maximum of 90 days per calendar year. Rehabilitation must begin within 14 days of the date of discharge from hospital.

Only on medical prescription and with the prior agreement of The Insurer.

K.9 : Abortion
If it is necessary to avert the danger of serious physical harm or a state of deep distress for the pregnant woman, The Insurer will pay the costs of a voluntary termination of pregnancy if this is not punishable under art. 119 of the Swiss Penal Code. The insurance Plan covers the costs of the same benefits as for illness, expenses related to complications of pregnancy or childbirth are not covered by this benefit.

K.10 : Child birth
In accordance with art. 13 of the Health Insurance Benefits Ordinance (OPAS), The Insurer will pay the medically necessary costs incurred during pregnancy and childbirth, including :

- hospital charges
- specialist fees
- the mother's pre- and post-natal care
- midwife fees
- newborn care
- three breast feeding advice consultations, but not more than CHF 150, when provided by a midwife, a midwifery organisation or a nurse with special training in this area

Examinations performed by doctors or midwives or examinations ordered by doctors are covered during and after pregnancy. We cover costs for seven routine examinations (two of which may be uterus scans between the 10th and 12th week as well as between the 20th and 23rd week of pregnancy, with additional uterus scans covered in the case of a high-risk pregnancy as part of this benefit) and post-natal examination (six to ten weeks after giving birth).

Childbirth in a general hospital ward in the canton of residence, or in a semi-inpatient situation, including preparation and aid provided by doctors or midwives, is covered, as well as up to three breastfeeding consultations.

Any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place.

Newborn care includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures is only covered during the stay in the hospital until discharge following a routine birth. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow-up investigations and treatment including complication are not covered for the newborn.

The newborn cannot be added to the insurance policy. It is also recommended to have adequate insurance coverage in place for the newborn before birth.

To benefit from maternity coverage, a prior agreement is required in the event of hospitalization only.

K.10.1 : Home delivery
Home delivery is covered if it is included in the chosen Care Plan, up to the limit indicated.

K.10.2 : Pre-natal care
Includes common screening and follow-up tests as required during a pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple or Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis covered by the insurance policy.

K.10.3 : Post-natal care
Refers to the routine post-partum medical care received by the mother, up to six weeks after delivery.

K.10.4 : Complications of pregnancy
Complications of pregnancy relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered :

- ectopic pregnancy
- gestational diabetes
- pre-eclampsia
- miscarriage
- threatened miscarriage
- stillbirth
- hydatidiform mole

K.10.5 : Complications of childbirth
Complications of childbirth refer only to the following conditions that arise during childbirth and that require a recognized obstetric procedure :

- post-partum haemorrhage
- retained placental membrane

Complications of childbirth include medically necessary caesarean sections.

K.11 : Diagnostic tests
Analyses, radiology, scans and MRIs are fully covered if they are performed to determine the cause of the presented symptoms and are prescribed by a doctor.

The CT scan is only covered only after prior acceptance by The Insurer.

K.12 : Vaccines
An amount of CHF 150 is allocated per period of 3 calendar years for compulsory vaccines, medically prescribed and recommended by the Federal Office of Public Health (FOPH) and the Federal Commission for Vaccinations.

K.13 : HIV test
An amount of CHF 50 max. is allocated per calendar year.

K.14 : Hydrotherapy treatments
For an allowance of a maximum amount of CHF 10 per day up to a maximum of 21 days per calendar year, the following conditions are applicable :

- treatment must be medically prescribed
- treatment must take place in Switzerland
- treatment must be part of treatment prescribed by a medical practitioner authorised to practise in Switzerland
- the prescriptions must be sent to The Insurer before commencing the treatment required

K.15 : Physiotherapy
Refers to treatment by a registered physiotherapist following referral by a medical practitioner and in the treatment of musculoskeletal or neurological diseases or diseases of the internal organ and vascular systems, insofar as these can be treated by physiotherapy.

Physiotherapy is initially limited to a maximum of 9 sessions per prescription, after which the insured person must be examined by the general practitioner who prescribed the sessions. The first session must be performed within 5 weeks of the date of the doctor's prescription.

In general, 4 series of 9 physiotherapy sessions per year are allowed per condition. Over 36 sessions of treatment. If more sessions are required, a new report justifying the need to extend the treatment must be submitted to the Insurer.

K.16 : Chiropractor
Expenses are covered up to 50% only if the insured person uses a chiropractor authorised to practice under a diploma recognized by Swiss law.

K.17 : Osteopath
The expenses are covered up to 50% only if the insured person uses an osteopath authorised to practice by virtue of a diploma recognized by Swiss law.

K.18 : Alternative medicines
90% of the costs, up to a maximum of CHF 1'500 per calendar year, for homeopathic, phytotherapy, acupuncture and anthroposophic medicine treatments, provided that the service is provided by one of the following providers :

- an authorised medical practitioner
- a recognised medical practitioner specialised in naturopathy
- a practitioner specialised in natural therapy APTN (NVS) (Full member)

K.19 : Emergency outpatient treatment
Cover under the emergency benefits is only for acute emergency healthcare needs in which the insured person may incur. Only treatment necessary to commence within 24 hours of the emergency event will be covered, when deemed medically necessary by a doctor and carried out by a registered physician.

This includes cover for treatment received in a casualty ward or emergency room, following an accident or any sudden beginning or worsening of a severe unforeseen illness, poses an immediate health risk to the insured person and requires emergency medical care.

This benefit does not include treatments which are necessary due to a pregnancy or any other exclusion.

K.20 : Optic glasses and contact lenses
Up to the age of 18, an amount of CHF 180 is allocated per calendar year for corrected glasses and contact lenses.

Only on medical prescription. Entitlement to optical services begins 6 months from the effective date of the contract.

K.21 : Emergency dental treatment after an accident
Maximum 80%. Treatment must be performed within 15 days and consist in replacing lost or damaged healthy and natural teeth.

K.22 : Means and devices
Only on medical prescription. It covers equipment that is medically defined as appropriate and necessary must :

- essential to identify or treat a patient's condition, illness or injury
- consistent with the patient's symptoms, diagnosis or treatment of the underlying condition
- in accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time. This does not apply to complementary treatment methods if they are part of the chosen insurance coverage
- required for reasons other than the comfort or convenience of the patient or his/her physician
- proven and demonstrated to have medical value
- considered to be the most appropriate type and level of service or supply
- provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition. This does not apply to complementary treatment methods if they are part of the chosen insurance coverage
- provided only for an appropriate duration of time

K.23 : Transportation costs
The Insurer covers 50% of the transportation costs, up to a maximum of CHF 500 per calendar year for expenses related to emergency transportation, medically requested to allow for care by the nearest authorised medical practitioner or the closest hospital for appropriate treatment given by the accepted practitioner which the insured person is allowed to choose.

K.23.1 : Transportation costs are covered only if the health of the patient does not enable him to use another private or public means of transport.

K.24 : Health repatriation
Repatriation costs for health reasons, outside Switzerland and outside country of origin, are fully reimbursed.

K.25 : Death benefit
In the event of the insured person's death, the amount indicated on the insurance certificate will be paid on the basis of the designation of a universal beneficiary, i. e. the spouse, failing which the children born or to be born in equal shares, failing which the parents in equal shares, the share of the predeceased accruing to the survivor, failing which the heirs in equal shares among them.

Art. L : Reimbursement

L.1 : Recognition of service providers
For treatment in Switzerland, only invoices by providers with degrees or with federal or cantonal authorization to practice the profession are taken into consideration.

L.2 : Outpatient : Third guarantor
To obtain reimbursement for outpatient treatment, including an invoice from a specialist or general practitioner, the insured person must send to The Insurer :

- the original invoice, detailed and fully paid
- a proof of payment of medical expenses
- the duly completed refund request Form
- its bank details (IBAN of bank or post office account)

Only the costs of treatments for which the insured person is covered will be reimbursed after taking into consideration any Treatment Guarantee requirements. Any deductibles or co-payments will be taken into account when calculating the amount to be reimbursed.

If the insured person are required to pay a deposit in advance of any medical treatment, the cost incurred will only be reimbursed after treatment has taken place.

L.3 : Stationary Salaries : Third party payment
In order to obtain reimbursement for inpatient treatment, hospitals must send the original, itemised invoice directly to The Insurer.

L.4 : Invoices issued abroad or overseas
In case of treatment abroad or overseas, only invoices prepared by providers qualified in the country where they are practicing and licensed to practice are taken into consideration.

L.5 : Requests and claims for reimbursement will be honored only if The Insurer believes that the amount of invoices and receipts provided is reasonable and customary. Otherwise, The Insurer reserves the right to reduce the amount of benefits.

L.6 : If fees are not detailed or insufficiently detailed, The Insurer will decide on the amount to be reimbursed.

L.7 : If a claim is, in any respect, false, fraudulent, intentionally exaggerated or if fraudulent means/devices have been used by the insured person or by anyone acting on his behalf to obtain benefit under this insurance policy, The Insurer will not pay any benefits for that claim.

L.8 : In the event of fraudulent claims, the contract will be cancelled by The Insurer in writing from the date of discovery of the fraudulent event and the amount of any fraudulent claims paid can be reclaimed by The Insurer (art. 40 VVG).

L 9 : Reimbursements which the insured person or the policyholder unrightfully receives from The Insurer must be returned to them within 30 days, including the costs incurred as a result.

L.10 : Subsidiarity and third-party benefits
We provide our insurance benefits following reimbursement of benefits by social insurers or other private insurers or other liable parties. If other private insurers are also liable to provide benefits following reimbursement of other parties, we shall render benefits based on the insured amount in proportion to the total of the insured amounts by all liable insurers. If a social insurer is compulsorily liable and we have provided initial insurance cover, we retain the right of reimbursement from either the insured person or the social insurer.

If liable third parties have an obligation to provide benefits for the consequences of illness or accident, we only guarantee to provide our benefits as advance payments and under the condition that the insured person transfers their claims against liable third parties to us up to the amount of the benefits rendered by us. If the insured person makes any agreement with liable third parties, in which they partly or wholly waive their claims to insurance benefits or compensation, without the consent of The Insurer, their entitlement to benefits from The Insurer becomes null and void.

L 11 : Assignment and pledging
Claims against The Insurer may not be pledged and may only be assigned to the benefit provider.

L.12 : Compensation
L.12.1 : The Insurer's claims against the insured person are offset against the benefits due.

Art. M : Obligations and justification of claims

M.1 : Generals obligations of the insured person
The insured person must, but is not limited to :

- submit to the instructions of the doctors
- do make every effort to inform and cooperate with The Insurer
- do everything in his or her power to contain damage to his or her health as far as possible
- not take part in risky actions and knowingly exposes himself to danger

M.2 : Prior acceptance
Reimbursement is subject to prior approval of The Insurer unless there was an emergency characterized in the following cases :

- any hospitalization outside of Switzerland
- home care outside of Switzerland
- costs of birth outside of Switzerland
- psychotherapy outside Switzerland
- MRI outside of Switzerland
- PET and CT-PET scans
- organ transplants
- physiotherapy costs outside Switzerland
- homeopath and acupuncturist fees
- spa treatment
- re-education outside of Switzerland

In the event of a serious emergency, the declaration to The Insurer must be made within 7 days of admission to the hospital.

Acceptance by The Insurer shall be obtained if it has not responded within 20 days following the receipt of the request or claim.

However, this tacit acceptance is valid only for the care provided within 30 days, following the initial period of 20 days.

In the event that this request or claim is not obtained during hospitalization or during any other treatment for which the service is possible, The Insurer reserves the right to refuse the claim for reimbursement.

M.3 : Justification of the claims
If insurance claims are required, the insured person undertakes to provide us with all detailed invoices, supporting documents from service providers and proof of payment must be sent to The Insurer. Only the original documents were taken into consideration.

Invoices and documents from abroad can be issued in French, German, Italian or English. For invoices and documents in other languages, a translation must be attached.

If health care insurance exists with another insurer, the detailed accounts of this insurer must also be provided.

M.4 : Violation of obligations
If the insured person violates its obligations to The Insurer in a claim for benefits, these may be reduced or denied.

Art. N : Claim notification

N.1 : Disease occurred abroad
If benefits are required in the event of illness occurring abroad, the form "declaration of illness occurring abroad" must be submitted immediately to The Insurer.

N.2 : Accident
If accident benefits are required, the "accident report" form must be submitted immediately to The Insurer.

Art. O : Coordination of third-party healthcare benefits

O.1 : Multiple Insurance
If, for the insured expenses, there is insurance coverage with several insurers, they are paid in total only once. In these cases, The Insurer shall bear the costs only on a proportional basis.

O.2 : Third-party health care services
The insured person are required to immediately notify The Insurer of third-party services and compensation agreements, provided that The Insurer must pay benefits in the same insured event.

O.3 : If The Insurer provides benefits instead of a responsible third party, the insured person must give up his rights to the extent of benefits provided by The Insurer.

O.4 : In a joint contract with another insurer, the two parties have the right to consult the medical record before and after the effective date of cover.

Agreements with third parties are not evidence for The Insurer.

Art. P : Exclusions

P.1 : Excluded risks
The following costs are not insured by The Insurer if they are induced by :

- damages resulting from a war or civil war, insurrection, riots, acts of terrorism, or public demonstrations, unless the insured person does not take an active part in the event
- a disaster resulting directly or indirectly from a nuclear explosion

The Insurer reserves the right to modify the coverages in one or more specific territories, subject to a fifteen-day notice period to the insured person or the policyholder.

P.2 : Excluded benefits and services
It is expressly specified that the following benefits and services are not covered by The Insurer :

P.2.1 : Any type of experimental or uncontrolled treatment that does not follow the generally accepted, usual or traditional medical practices, except with the specific consent of The Insurer.

P.2.2 : The supplementary cost for a single room (private ward) in case of hospitalization.

P.2.3 : Preservative dental care, orthodontics and dental prosthesis, unless provided for by contract.

P.2.4 : Ancillary or comfort costs during hospitalization (TV, telephone…).

P.2.5 : Expenses incurred to acquire an organ.

P.2.6 : Any operation or treatment related to a sex change.

P.2.7 : Aesthetic treatment, rejuvenation or dietary treatment.

P.2.8 : Treatment for self-awareness, personality improvement and self-accomplishment or for any other reasons not aimed at treating an illness.

P.2.9 : Treatment for overweight or underweight, cell therapies, treatment to gain strength.

P.2.10 : Any measure ordered by a judicial or administrative entity, for ex. therapy replacing a sentence, BAC or drug test.

P.2.11 : Treatment in case of military service abroad or overseas and/or subsequent treatment.

P.2.12 : Verification, research, treatment and complications related to sterility, sterilisation, sexual disorders, contraception including insertion and removal of contraceptive devices, abortion, except if not punishable as per art. 119 of the Swiss penal code of law.

P.2.13 : Any elective surgery, any voluntary surgery and/or plastic or cosmetic surgery whether for medical, psychological or any other reason, as well as any cosmetic or aesthetic treatment to enhance the appearance of the insured person, even when medically prescribed.

P.2.14 : Hydrotherapy cures and treatment outside of Switzerland.

P.2.15 : Transportation and accommodation costs related to hydrotherapy treatment.

P.2.16 : Medical expenses related to the following stays, even if they are medically prescribed :

- in thalassotherapy centers
- in a fitness center
- convalescent home
- in a nursing home

P.2.17 : Consultations, treatment and complications due to hair loss or transplant unless the hair loss treatment is related to a severe illness.

P.2.18 : Eyesight corrective treatment to modify the refraction of an eye or the eyes (laser sight correction) including refractive keratotomy (RK) or refractive photo keratotomy (RPK).

P.2.19 : Non-prescription drugs, over-the-counter (OTC) drugs and commonly used non-drug products such as medical alcohol, cotton wool, sunscreen, dental hygiene products, dressings, shampoos, food products (including those intended for special diets, mineral waters and tonic wines, fresh and dry gland preparations, contraceptive products, cosmetics, sanitary products, antibaldness products, the products classified as vitamins or minerals, special infant formulas).

P.2.20 : The following treatments, medical conditions or procedures, or any adverse consequences thereof, are not covered :

- dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral and maxillofacial surgical procedures
- prescribed nicotine replacement therapy products
- preventive treatment
- routine health checks
- oculomotor therapy
- speech therapy
- occupational therapy

P.2.21 : Treatment outside the geographical area of cover, unless for emergencies or that the Insurer has authorized the processing.

P.2.22 : Consultations performed, as well as any drugs or treatments prescribed, by the insured person, his spouse, one of his parents or one of his children.

P.2.23 : Treatment required as a result of medical error.

P.2.24 : Investigations into, and treatment of, obesity.

P.2.25 : Treatment of sleep disorders, including insomnia, obstructive sleep apnea, narcolepsy, snoring, and bruxism.

P.2.26 : Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded under the chosen Care Plan.

P.2.27 : Gross negligence or deliberate cause of an accident, particularly in the case of abusive use of alcohol and other drugs, benefits may be reduced or refused in serious cases.

P.2.28 : Expenses incurred as a result of illness or accident which are the deliberate act of the insured person, deliberate or self-inflicted injuries, deliberate or self-inflicted mutilation, or attempted suicide.

P.2.29 : Fees for the completion of a Claim Form or other administration charges.

P.2.30 : Treatment directly related to surrogacy, whether the insured person is acting as a surrogate, or are the intended parent.

P.2.31 : Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

P.2.32 : Music or video therapies.

P.2.33 : Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

P.2.34 : Paramedical treatments, with the exception of the treatment methods indicated in the Policy Conditions (PC) and covered by the chosen Care Plan..

P.2.35 : Home visits, unless they are necessary following the sudden onset of an acute illness, which renders the insured person incapable of visiting their medical practitioner, physician or therapist.

P.2.36 : The treatments, the medical conditions and procedures or any adverse consequences or complications resulting therefrom that are not indicated in the insured person's Care Plan.

P.2.37 : Events that have already occurred at the time the insurance policy is taken out or the event is declared, or events that the insured person should have known about at the time the insurance policy is taken out or the event is declared.

P.2.38 : Events related to epidemics or pandemics.

P.2.39 : Events related to participation in risky actions, where the insured person knowingly exposes himself to danger.

Art. Q : Confidentiality

Q.1 : Data entry, request for information
The insured person allows The Insurer to enter all data in the computer system and gather the information necessary for payment of the entitlement to benefits and services.

Q.2 : Data protection and privacy
Data acquisition and processing serve the business of insurance transactions, marketing, selling, administration, mediation of products and services and risk assessment, as well as the handling of insurance contracts and any secondary business associated with this.

The confidentiality of information relating to the Insured is of paramount importance for The Insurer. To this end, The Insurer complies with strict legislation on data protection and confidentiality guidelines in the medical field in force in countries where it operates.

Art. R : Necessary information to be provided

R.1 : Change of status name, marital status and address
Changes in name, status, marital status, address, email address, in particular canton or death must be notified in writing to the Insurance Agency within 30 days. In cases of lateness or omission, The Insurer reserves the right to claim back any expenses incurred.

R.2 : The Insurer may have to carry out verifications related to the status or marital status of the insured person, who must then provide all the information requested in relation to the above-mentioned criteria.

R.3 : If The Insurer does not have all the documents needed to verify the status of the insured person or the eligibility criteria indicated in art. B of the Policy Conditions (PC), The Insurer will terminate the contract for each insured person on the last date on which he/she could validly prove his/her status.

R.4 : The last known address of The Insurer is legally valid.

Art. S : Assistance

S.1 : In case of illness or accident
If the Insured person is affected by an illness or is victim of an accident outside of Switzerland and outside of his country of origin and cannot be treated on site (whether or not the hospitalization occurred under the control of Advisor Assistance), Advisor Assistance will organize and take charge of :

- Transport to a regional center or a neighboring country capable of providing the appropriate care and, subsequently, repatriation to a country of the European Union, to Switzerland to the country of origin, if the state of health of the insured person at that time justifies it.

- Depending on the seriousness of the case, transportation or repatriation can be organized under medical surveillance in the same conditions of cover.

Transportation or repatriation can be organized by :

- special air ambulance or a regular airline
- train, coach, ship, or ambulance

S.2 : In the event of death
S.2.1 : Advisor Assistance organizes and takes charge of the transportation of the body of the Insured person from the place of death to the place of burial or cremation in his country of origin.

S.2.2 : Advisor Assistance covers the additional costs necessary to transport the body, including the cost of a coffin of a simple model (maximum CHF 1'000 incl. tax) for transport.

S.2.3 : The ceremony costs, accessories, burial or cremation in the country of origin of the insured person are the responsibility of the family/families concerned.

S.2.4 : If the said expenses have been prepaid by Advisor Assistance, the Company, the insured person or the rightful heirs will reimburse the amount upon request by Advisor Assistance.

S.2.5 : Advisor Assistance will also prepay hospitalization expenses for the Insured person abroad or overseas within the conditions of the repatriation guarantee.

S.2.5.1 : Parental presence in case of hospital stay of more than 7 days
In the case of hospitalization outside Switzerland and outside the country of origin, the expected duration of which is greater than 7 days or in the event of death of the insured person outside Switzerland and outside the country of origin, Advisor Assistance is in charge of organizing from the trip to the relevant location for a family member.

Transport and accommodation costs will be covered up to a maximum of CHF 4'000 per event.

The trip must in all cases be organized with the prior consent of Advisor Assistance.

Family members are solely responsible for non-compliance with customs formalities in their country of origin and destination.

S.2.5.2 : Theft of personal documents (passport, visa, identity card)
In the event of the theft of personal documents (passport, visas, identity card) outside Switzerland and outside the country of origin which temporarily prevents the continuation of the journey by the insured person or his return to his residence in Switzerland, the costs Additional accommodation (transport and accommodation) will be paid by Advisor Assistance up to CHF 1'500 maximum for each event.

This guarantee will be issued only if the insured person has immediately complained to the police authorities of the country in which it is located; the flight declaration must be sent to Advisor Assistance.

S.2.5.3 : Postponement of travel in case of change of university examination dates
If the university authorities decide to change the examination dates, thus making it necessary to postpone the return flight to the country of origin or to delay departure to the country of origin, Advisor Assistance will pay the additional costs of postponement / delay of departure until maximum of CHF 150 per insured person per year, provided that the reservation was made before the university authorities decided to change the examination dates.

The insured person will send Advisor Assistance as soon as possible the following supporting documents, namely the certificate from the university authorities changing the examination dates, the confirmation of the initial booking, the certificate indicating the new travel dates and the deferral costs charged by the service provider.

S.2.5.4 : Search and rescue costs
Advisor Assistance coordinates the necessary search and rescue operations. The accompanying costs are covered by Advisor Assistance up to a maximum of CHF 50'000 per insured person and any one event.

S.3 : Supplementary services
S.3.1 : Telephone medical service
Advisor Assistance gives the insured persons access to a 24/7 telephone medical advice service.

With a simple telephone call from the insured person, one of the Advisor Assistance medical practitioners will answer any medical questions and can provide names and addresses of practitioners or medical institutions, specialized or not, capable of receiving him.

S.3.2 : Third-party payment for hospital expenses outside Switzerland and outside the country of origin in case of emergency or accident.

S.3.3 : In case of hospitalization lasting more than three days outside of Switzerland and outside of the country of origin, Advisor Assistance will prepay the expenses guaranteed by the Advisor International Health Insurance contract if the expenses have been incurred under the control of Advisor Assistance.

S.3.4 : Shipment of medicines
Advisor Assistance takes all measures to supply and dispatch the necessary medication to continue on-going treatment, if after unforeseen circumstances, the Insured person cannot find the prescribed medication or the equivalent on site.

The costs of this medication are charged to the Insured person.

S.4 : Conditions of intervention
S.4.1 : The organization, by the Insured person or by a third party, of any of the above-mentioned types of intervention will not result in any reimbursement by Advisor Assistance.

S.4.2 : In all cases, the decision and conditions of repatriation or transfer to an appropriate medical institution belong exclusively to an Advisor Assistance medical practitioner after contact with the medical practitioner on site, and eventually with the family of the Insured person.

S.4.3 : When Advisor Assistance organizes and takes charge of the repatriation to an EU member state, if this is the origin country of the Insured person, he can be asked to use his travel ticket.

S.4.4 : When Advisor Assistance organizes repatriation to an EU member state, if this is the origin country of the Insured person, the return trip cost cover will be up to the additional costs incurred by the change of health resulting from the illness or the accident which caused the intervention.

S.4.5 : Advisor Assistance can only intervene within the limits of agreements with local authorities.

S.4.6 : Advisor Assistance can, in no case, substitute local rescue emergency organisations nor cover the expenses thus incurred.

S.4.7 : Advisor Assistance will not be required to intervene in cases where the insured person has voluntarily committed breaches of the law in force in the country in which it is located.

S.5 : Subrogation
Any person benefiting from the assistance commits to subrogate Advisor Assistance in his rights and actions against any responsible third party up to the amount of expenses engaged in the execution of this guarantee.

S.6 : Prescription
Any action deriving from the present guarantee is prescribed within a period of two years from the date of the event causing it.

S.7 : Responsibility – Exclusions
Advisor Assistance will not be held responsible for failure or delay in the execution of its obligations if caused by case of force majeure.

S.7.1 : In addition, cover of repatriation costs cannot be obtained for the following cases :

S.7.1.1 : Pregnancies.

S.7.1.2 : If after a first repatriation, the insured person relapses less than twelve months after his return.

S.7.1.3 : Risks of war
The consequences of a civil or foreign war, insurrection, riot or civil commotion, wherever and by whomever these events take place, unless the insured person does not actively participate in them, or is called upon to carry out a maintenance or surveillance mission to maintain the safety of persons and property for the benefit of the insured person.

Advisor Assistance reserves the right to modify the guarantees on one or more specific territories, subject to a fifteen-day notice period, in addition, in the event of war where Switzerland would be belligerent, the guarantee would not be granted.

S.7.1.4 : Air travel risks
The consequences of an accident during competitions, air demonstrations, acrobatic flights, expeditions, attempts to break records, flights on prototypes, flight tests, parachute jumps with non-certified parachutes, and military flight personnel activities in which the Insured person participated.

Consequences of an air travel accident are covered by the guarantee only in the following cases :

- the aircraft has a valid flight certificate
- the crew members (of which the Insured person can be part) hold valid certificates, licences, and qualifications as required by their activity on board, in line with the appropriate aircraft, the nature of the flight and with the appropriate authorizations when required

S.7.1.5 : Events occurring on the territory of the USA or for repatriation to the territory of the USA.

S.7.1.6 : Repatriation (for medical reasons or in case of death) to or from countries or zones to which the Swiss Federal Department of Foreign Affairs (DFAE) advises against travel and countries in a state of war, revolution, rebellion or other internal disorder.

S.8 : Other excluded risks
The consequences of :

S.8.1 : Illness or accident which are the deliberate act of the insured person, deliberate or self-inflicted injuries, deliberate or self-inflicted mutilation, or attempted suicide.

S.8.2 : A terrorist attack or attempt unless the insured person did not take an active part.

S.8.3 : The suicide of the insured person before the end of two years of insurance.

S.8.4 : A surgical operation required by an accident excluded by the insurance.

S.8.5 : Drug use without any medical prescription.

S.8.6 : The participation in a duel, a crime, an intentional offence, a fight, except in the case of legitimate defense and assistance to a person in danger.

S.8.7 : The professional participation in sports and competitions.

S.8.8 : The participation in military and police activities.

S.8.9 : The ownership, possession or manipulation by the insured person of war devices or the holding of a prohibited weapon on the site of the accident.

S.8.10 : An act of belligerence or terrorism whether responsibility for it was claimed or not.

S.8.11 : The participation of the insured person in any competition (or tryout) necessitating the use of a motor vehicle or a motor boat.

S.8.12 : An accident resulting from bungee-jumping, and the use by the insured person (including as a passenger) of hang-gliders, parasail, motorised ultra-light aircraft or any other aircraft not certified for public transportation.

S.8.13 : A disaster resulting directly or indirectly from a nuclear explosion.

S.8.14 : Sudden climate changes such as storms or hurricanes.

S.9 : : Implementation of the guarantees
Any request for assistance, to be admissible, must be formulated directly by the insured person (or any person acting on his behalf) by indicating the name of the insured person and the number indicated on the certificate of insurance.

Téléphone +41 22 593 73 04
E-mail help@europ-assistance.ch

Art. T : Risk carrier and applicable law

Any dispute relating to the interpretation or execution of the present contract which cannot be settled amicably will fall within the jurisdiction of the Swiss courts.

T.1 : Health insurance
In accordance with the art. 2.4 of the Health Insurance ordinance (OAMal), the risk is insured by MGEN International Benefits, which has delegated the entire management of this insurance program to Advisor International Health Insurance.

T.1.1 : Insurance coverage is governed by the Federal Law on Health Insurance (LAMal) and the applicable ordinances.

T.1.2 : The insurance contract is governed by Swiss law law governing the insurance contract.

T.1.3 : Insurance coverages that are complementary are to be regarded as complementary insurance and are subject exclusively to Swiss law governing the insurance contract.

T.1.4 : Should one, or several of the clauses be declared null and void or not applicable, this does not have any effect on the other clauses of these conditions. They remain fully applicable.

T.2 : Assistance
The risk is insured by Europ Assistance, which has delegated the entire management of this insurance program to Advisor International Health Insurance.

T.2.1 : The insurance contract is governed by Swiss law law governing the insurance contract.

Art. U : Insured Persons under a group insurance policy

The policyholder who sets up a group insurance policy benefits from simplified administrative procedures. These procedures are intended to reduce the admission formalities and are in no way intended to deprive The Insurer of the opportunity to assess the object of the risk or to reduce its opinion.

U.1 : Characteristics does the insured person have to meet for insurance under a group insurance policy
The insured person must belong to the group of individuals eligible for insurance pursuant to the group insurance policy. If this characteristic no longer applies, the cover shall end.

U.2 : Obligations of The Insurer
A certificate of insurance is issued in the name of each insured person under a group insurance policy. It is made available to the insured person in accordance with the instructions of the policyholder who sets up a group insurance.

U.3 : Obligations of the insured person
The insured person is responsible for the statements contained in his registration file, in particular in the section reserved for his state of health, and in any other written document. All these documents form the basis for adhering to a group insurance policy.

U.4 : Start and end of participation in a group insurance policy
Participation under a specific group insurance scheme shall start not earlier, than the point in time agreed for this group insurance policy in the group insurance contract. The inception of cover cannot be before the start date of the group insurance scheme. Cover for the insured person cannot exceed the validity of the group insurance contract.

U.5 : Transition to individual insurance
If the insured person requests cover as an individual insurance, she must complete a new insurance application and send it to The Insurer at the latest 30 days before leaving a group contract.

The insurance application will be subject to the standard conditions for admission and eligibility of individual insurance and the Policy Conditions (PC) of individual insurance.

The request cannot be backdated and all eligibility criteria's for cover as set out under Policy Conditions (PC) needs to be met.

Art. V : Complaints and appeals

V.1 : Complaints
We welcome comments on aspects of insurance coverage that the insured person has particularly appreciated or that have caused problems. In the event of a claim, we have put in place a simple procedure to ensure that claims are processed as quickly and efficiently as possible.

For any comments or complaints, the insured person can call Advisor International Health Insurance's customer service at :
+ 41 21 620 75 00

The insured person can also write to us at the following address :
Advisor International Health Insurance
Avenue de Provence 4
CH-1007 Lausanne
Switzerland

V.2 : Second instance
If we have not been able to resolve the insured person's claim and the insured person wishes to file an appeal at second instance, he or she may contact the Advisor International Health Insurance « Complaint Manager » at :
+41 21 620 75 00

It is very rare that the Complaint Manager is unable to respond to a complaint. If necessary, the insured person may refer the claim to an independent body for examination.

V.3 : Procedure in the event of an objection
V.3.1 : If the insured person does not accept a decision of the insurer, the insurer shall notify him in writing within 30 days, stating the reasons, the right to object and the time limit for doing so.

V.3.2 : An objection may be lodged against the decision of the Insurer within 30 days of its communication to the head office of the Insurer.

V.3.3 : The notification or the decision on the opposition becomes res judicata if no appeal is lodged within the relevant time limits or if the decision on the opposition or the judgment is enforceable.

Advisor International Health Insurance insures people of all nationalities. Strict control of the rules imposed by the Swiss Insurance Contract Act and the Swiss Financial Market Supervisory Authority FINMA guarantees the best possible security for our clients.

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FINMA under number 34’892